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JOURNAL OF MEDICINE

Vol. 11
No. 8



August
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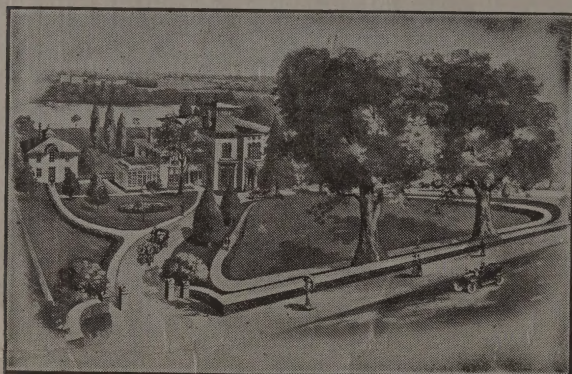
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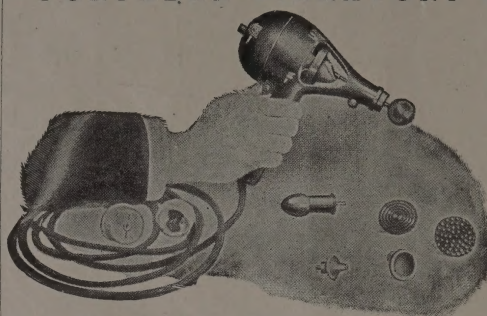
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Original Articles

EXOPHTHALMOS, A COMMON SYMPTOM OF CHRONIC BRIGHT'S DISEASE.*

By HERMON C. GORDINIER, M.D.,

TROY, N. Y.

MY object in presenting this preliminary and brief communication is to direct the attention, particularly of the general practitioner, to the common occurrence of exophthalmos and the associated external ocular signs in chronic nephritis, and to emphasize the importance of these signs from a diagnostic standpoint.

We are all more or less familiar with the ocular manifestations of chronic Bright's disease discoverable by ophthalmoscopy, such as retinal hemorrhages, albuminuric retinitis, arterio-sclerotic changes in the vessels of the retinae, neuroretinitis, etc., but I feel reasonably sure that exophthalmos, a very common objective symptom of nephritis, has been entirely overlooked because we have not been cognizant of its association with Bright's disease. This has been due for the most part to the absence of any reference to this sign in our standard text-books or systems of medicine, or in special treatises on the subject of nephritis. So far as I have been able to ascertain from a careful search of the literature, the only article which has appeared on this subject is the one by Prof. Barker and Dr. F. M. Hanes, of the Johns Hopkins School, read before the Association of American Physicians in Washington in May, 1909. They state that among the total admissions of thirty-three cases of chronic nephritis during the first four months of 1909, sixteen (or 48.4 per cent.) showed exophthalmos. The exophthalmos varied greatly in degree, as did the gravity of the nephritic processes in the various individuals. Indeed, it may be stated that these cases, presenting evidences of serious intoxication (suburemic and uremic symptoms) most frequently showed exophthalmos and one or more of the allied ocular signs—anisocoria, von Graefe's, Moebius or Stellwag's sign. Exophthalmos has been an obvious sign in all of the cases of chronic nephritis which have died in the Johns Hopkins Hospital since 1909—seven in number. We have also observed that the cases of chronic nephritis showing albuminuric retinitis during this period, have invariably shown exophthalmos. In this series of sixteen cases von Graefe's sign was positive in eleven, Stellwag's was positive in thirteen, and Moebius' sign was observed in eight cases. The pupils were unequal in five cases, and albuminuric retinitis was observed in eight cases. In twelve out of the sixteen cases exophthalmos

was associated with arterial hypertension, and in two cases a maximum degree of exophthalmos was associated with the maximum degree of arterial tension and, as the blood pressure fell, the eyes became less prominent.

My observations entirely corroborate those of Drs. Barker and Hanes. I have had during the past year the opportunity of studying twenty-eight cases of chronic nephritis—two of the chronic parenchymatous type and twenty-six of the chronic interstitial form. Of this number fourteen presented exophthalmos of varying degrees, together with one or more of the associated ocular manifestations. The two cases of large white kidneys presented a marked degree of exophthalmos. They were observed late in the disease, suffering with marked renal and cardiac insufficiency and uræmia.

The cases of the chronic interstitial type of nephritis—twenty-six in number—all presented hypertension, left, and occasionally right-sided cardiac enlargement, with accentuation of the aortic and occasionally of the pulmonic second sounds and the urinary findings that exist in this type of disease. Of this number twelve presented exophthalmos, von Graefe's and Stellwag's sign, and seven the sign of Moebius. In three cases the pupils were irregular. In five cases the exophthalmos seemed more marked on one or other side. In two of the cases the enlargement was greater on the left side, and in three on the right. In none of the cases that have come under my observation was the thyroid gland visible or palpable. The exophthalmos, although most marked in the advanced cases suffering from serious toxæmic manifestations, was distinctly visible in those of a less advanced type with fairly compensated hearts and without distinct uræmic manifestations. In five of the twelve cases with exophthalmos albuminuric retinitis was present, and in six cases arterio-sclerotic changes in the vessels of the retinae with hemorrhages were observed. In none of the cases was tachycardia a prominent symptom.

The most probable explanation of the exophthalmos and associated ocular signs in chronic nephritis (von Graefe, Stellwag and Moebius) is an irritation of the cervical sympathetic system of fibers by toxins floating in the blood stream the result of a chronic renal insufficiency. We know both by clinical and experimental observations that paralytic lesions of the oblongata and cervical part of the spinal cord and section of the cervical sympathetic fibers produce exophthalmos, narrowing of the palpebral fissure and contracted pupils; and we also know from the early observations of Claude Bernard that when the cervical sympathetic fibers are stimulated the converse occurs, namely, widening of the palpebral fissure, exophthalmos, and dilatation of the pupil. Aran and Kaufman demonstrated in 1860 that this exophthalmos resulted from stimulation of Muller's non-striated muscle in the eyelids, which experiments have been more

* Read before the Medical Society of the State of New York, at Albany, April 19, 1911.

COUGHLIN

recently confirmed by Macallum and Cornell in 1904. The course taken by the fibers of Muller's orbital muscle and their action has been recently described by Landstrom. He finds that these fibers of smooth muscle form a narrow cuff encircling the anterior portion of the orbit. The fibers of the posterior portion of the cuff pass backward and are inserted into the sclerotic coat of the eyeball, while the fibers of the anterior margin of the cuff are inserted into the upper or lower lids, running obliquely toward the palpebral slit. The middle portion of the cuff constitutes the fixed point from which the muscle acts and is attached by short fibrous bands to the bony wall of the orbit. Hence when the muscle contracts it tends to draw the eye forward, producing exophthalmos; to separate the lids, creating Stellwag's sign, and to cause the axes of the eyes to diverge, with the production of the sign of Moebius.

In conclusion I would state that we have in exophthalmos and its associated external ocular signs valuable objective symptoms that should make us keen to the presence of chronic nephritis, particularly if unaccompanied by thyroïdal enlargement or marked tachycardia. And while exophthalmos accompanies Graves' disease, paralysis agitans, retro-bulbar growths, brain tumor, sinus, thrombosis or hydrocephalus, and prominent eyes occur in cases of myopia and tuberculosis, its presence should always lead us to carefully consider in our differential diagnosis chronic nephritis.

Discussion.

DR. L. F. BISHOP, New York City: I have had this question of exophthalmos in mind for some time, and I have observed a good many cases in hospital work, particularly of chronic Bright's disease, and I would like to confirm what every physician will confirm when he thinks back himself, that most cases of Bright's disease have more or less exophthalmos. I have also observed that this rather serious sign only occurs in cases that are well developed, and in which the prognosis is not very good. In one of my private patients it seemed to me that the exophthalmos varied with the patient's condition, and when this patient's kidneys were in bad shape and tension was high and auto-intoxication severe, the prominence of the eyes was much more than at times when she was in a good condition. It is rather curious that such a very prominent symptom should have been formally noted so late as two years ago—a symptom that every one sees in Bright's disease just as soon as it is brought to his attention.

I congratulate Dr. Gordinier on the lucid way in which he has presented this subject. I think it is a very interesting one.

DEATHS OF ATHLETES AND FATALITIES IN ATHLETIC GAMES DURING THE YEAR 1910.*

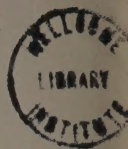
By ROBERT E. COUGHLIN, M.D.

THERE never could be anything more tragic than the sudden and accidental death of an athlete while publicly engaged in an athletic contest or game. A few moments before we have a strong, well built, sturdy, well muscled, splendidly proportioned individual whose whole thought for several months was the preservation of all his natural forces and the development of a superior musculature. He has been abstemious at all times, has denied himself all pleasures and luxuries, has sacrificed his time and everything in life to one end, namely, that he may be "fit" when called upon at the supreme moment. Watch him as he goes into the contest with eyes bright and sparkling, cheeks pink or rosy, skin clear and hard appearing, with muscles moving and gliding underneath the natural body covering with such ease and flexibility as to suggest well oiled machinery. All the functions of normal muscles are brought into play. The unstriped or involuntary as well as the striped or voluntary muscles enter into these processes. Chemical, thermic, electrical changes are going on along with contractility, conductivity and irritability all producing in one word motion. There never is a time when muscles respond so promptly and quickly as when an athlete is in condition. The step is elastic and bounding. There is a feeling as if one would like to spring into the air and fly. All is action and the stored up energy is difficult to realize or estimate. When we consider this picture and contemplate the possibilities which may occur in a few hours, or a few minutes, or a few seconds, or in the actual time of a dream, which is the time it takes a book to drop to the floor, one is simply horrified. Something awful has occurred and our athletic hero lies before our eyes a bruised, bleeding, lacerated, crushed, hardly recognizable mass of quivering, functionless organic matter. What a change and what a pity?

There never was a sport or pastime or an occupation for that matter that did not have some element of danger attached to it. Life insurance companies point out hazardous occupations such as bridge builders, caisson workers, linemen, crane men, blast furnace employees, jockeys, policemen, prison guards, raftsmen, switchmen, trackwalkers, steeple-painters and repairers, submarine operators, tunnel construction workers, trench and well diggers. Nearly all these occupations will make it difficult for the applicant to secure insurance.

Sometimes a fatal accident will be the result of a misstep or carelessness, as for example,

* Read before the Medical Society of the County of Kings, at Brooklyn, June 20, 1911.



the "steeple Jack" who stumbled down stairs in his own home causing a fracture of the neck with prompt death; or the mountain guide who was known for his courage and carefulness who one day while in his home attempted to hang a picture on the wall and in doing so lost his footing, fell on his head, fracturing his skull and died as the result.

In the year 1905 the writer collected the statistics of the deaths of athletes and fatalities in athletic games with the result that he was enabled to draw a few conclusions therefrom. (See *Medical Record*, June 2, 1906.) With the hope that a comparison of the year 1905 with the year just closed might be at least interesting he determined to collect all the deaths of athletes from whatever cause and all fatalities in athletic games or contests beginning January 1, 1910, and ending December 31, 1910. In presenting these figures the hope has been fostered that we may decide in this manner if possible the susceptibility of athletes to certain diseased conditions and the most dangerous or fatal games indulged in.

The whole number of deaths collected amounted to two hundred and six as against one hundred and twenty-eight in 1905. Fifty-one were due to disease as compared with fifty in 1905. One hundred and twenty-nine were accidental deaths due directly to games or contests, while in 1905 seventy-eight deaths were due to accidents of different kinds. There were nine deaths by accidents which were not connected with games or contests. There were also seventeen deaths of athletes by disease the name of which could not be ascertained.

Of the deaths by disease forty-eight were stated the average age being forty-one years as compared with thirty-one years of age in the year 1905. The oldest age at death was eighty-five, as against eighty-seven in 1905. The youngest was sixteen years of age as compared with eighteen years in 1905.

Of the deaths by accident seventy-eight were stated, the average age being twenty-two years and six months. In 1905 the average age was twenty years. The oldest age attained was sixty-seven years, while in 1905 the oldest age was sixty years. The youngest age was eleven, while in 1905 the youngest age was twelve years. The average age at death of the whole number was twenty-eight years and nine months. In 1905 the average age was twenty-six years and one month.

Of the deaths by disease, heart disease was stated to be the cause of death in eight cases; typhoid fever in six; pulmonary tuberculosis in three; senility in three; pneumonia in two; Bright's disease in two; peritonitis in one; goitre in one; locomotor ataxia in one; hemorrhage in one; appendicitis in one; empyema in one; cancer in one; insanity in one; complication of diseases in one; operation in one; artero-sclerosis in one; paralysis in one; apo-

plexy in one; liver disease in one, and septic wound in one. In 1905 cerebro-spinal meningitis was stated to be the cause of death in nine cases (owing to an epidemic of the disease during that year); cardiac disease in eight; pneumonia in seven; pulmonary tuberculosis in seven; Bright's disease in five; appendicitis in four; typhoid fever in four; suicide in two; apoplexy in one; suppurative tonsillitis in one; splenic anemia in one; senility in one.

During the year just closed forty-six football players died—thirty-three of these deaths were directly due to the game; seven were caused by disease; three were due to accidents which had nothing to do with the sport, while four were from unknown causes. In 1905 football was the cause of death in twenty-eight cases, seventeen were high school players, all immature boys of eighteen years or under. Three were physically fit college men while the others were occasional players.

In 1910, nine were physically fit college men, ten were high and public school boys, while eight were occasional players of the game.

The causes of death in football fatalities were stated as follows: Fracture of the skull, 10; internal injuries, 7; septic wound of leg, 4; injury to spine, 2; fracture of spine, 2; concussion of brain, 2; acute dilatation of heart, 1; brain hemorrhage, 1; tumor of spine, 1; paralysis of spine, 1; goitre from blow on neck, 1; old contusion, 1.

The deaths of football players by diseased conditions were: Typhoid fever, 3; pneumonia, 1; peritonitis, 1; Bright's disease, 1; cardiac disease, 1. Other deaths occurred which had nothing to do with the game, such as train accidents, suicide and foul play.

Of 499 accidents, not including deaths, the injuries were as follows: Accidents at first regarded as critical, 17; concussion of brain, 12; taken from field unconscious, 14; broken collar bones, 66; broken legs, 36; broken noses, 35; broken ribs, 26; broken arms, 19; broken ankles, 17; broken fingers, 15; broken shoulders, 11; broken wrists, 10; broken toes, 7; broken hands, 5; broken jaws, 2; broken cheekbones, 2; dislocations, 52; lacerations, 43; torn ligaments, 32.

Thus it will be seen that the new rules instituted in 1910 have apparently increased the number of accidents while they have not diminished the number of deaths. For comparison we will review the football fatalities and injuries for the past ten years as follows:

In 1901, 7 killed, 74 injured; 1902, 16 killed, 106 injured; 1903, 14 killed, 63 injured; 1904, 14 killed, 276 injured; 1905, 28 killed, 200 injured; 1906, 14 killed, 160 injured; 1907, 15 killed, 166 injured; 1908, 11 killed, 304 injured; 1909, 30 killed, 216 injured; 1910, 33 killed, and 499 injured.

Football economics show that it costs the average college like Harvard, \$35,000 to put a

team through a course of six or eight weeks. Some have figured \$1,200 per player. Thirty-five men have to be taken into consideration and not eleven as one would suppose.

As a matter of interest one death, namely Ralph Wilson, was attributed to the new rules. Wilson was crack right halfback on the Wabash (Ind.) College football team. He was killed in a trick play such as is encouraged under the new rules. Although he weighed 175 pounds he was regarded as the speediest and most brilliant player on the team. Accounts read that he made the first touchdown for his team by a long run. A little later Coach Bender called for one of his fake end runs, which consisted of sending a wedge around an end to mislead the opposing team, while a halfback dashes with the ball through an opening made for him by a guard, who steps to one side. A player of the St. Louis University team scenting the subterfuge when the Wabash guard stepped aside, leaped into the breach. Wilson, hurling forward at a tremendous speed, crashed against his knee, fracturing his skull. In commenting on this death Dr. D. C. Todd said: "The new rules hark back to the game as it was played in 1900 and I pointed out when the mass play first began to come into favor that it was less dangerous than open play. The danger in football is not from weight but from momentum and speed. The new rules make for speed and momentum. They lead to the use of lighter players because they require faster men. When you reduce the size of your player you reduce his resisting power in motion, and as a result, when he is thrown, he is more liable to injury than a heavier man would be."

The death of Captain Rudolph Munk of the West Virginia University team resulted in the arrest of an opposing player charged with murder. The testimony on which the warrant was issued was furnished by a Pittsburg attorney, who umpired the game. The umpire stated that the ball was on Bethany's 30-yard line when Munk started down the field for interferences. "He was met by McCoy, who ran toward Munk as they both were running down the field. Ten yards behind the scrimmage line, when Munk was in front, McCoy struck him in the back of the head with his fist, Munk fell and McCoy fell also, but quickly regained his feet, looked at Munk and started off the field." Umpire Young said the blow appeared to him clearly intentional and he ordered McCoy out of the game. The autopsy disclosed the fact that Munk's death was caused by a blood clot at the base of the brain and could not have been caused by a former injury.

During the year 1910, 55 baseball players died, 24 of these deaths were directly due to baseball, 15 were caused by disease, 3 were

caused by accidents which had nothing to do with the game and 13 died from unknown causes. In 1905, 12 deaths were due to baseball.

Of the 24 accidental deaths occurring during 1910, none of the deaths were among the first-class professional players, 2 were semi-professional players, 2 were high school boys, 5 were public school boys, 2 were business men while the rest were unclassified.

The accidental deaths due to the game were as follows: Fracture of the skull, 9; fracture of neck, 3; heart blow, 4; acute dilatation of heart, 2; internal injuries, 1; struck by ball, 1; blow in abdomen, 1; cerebral hemorrhage, 1; infected knee, 1; falling off bleachers, 1. In 1905 the causes of death in the 12 cases were stated as follows: Shock from blow over cardiac area, 5; head injuries, 4; cardiac failure while running to base, 1; blow in abdomen, 1; heat exhaustion, 1.

Of the 15 baseball players who died during the year just closed from diseases of different kinds the disease was stated as follows: Cardiac disease, 3; insanity, 2; pulmonary tuberculosis, 1; pneumonia, 1; complication of diseases, 1; locomotor ataxia, 1; hemorrhage, 1; appendicitis, 1; empyema, 1; cancer of throat, 1; typhoid fever, 1; operation, 1.

The accidental deaths which had nothing to do with the game of baseball were from falls and suicides; 2 were due to the former cause and 1 from the latter.

In the greater number of instances of accidental deaths due to the game blows over the temple were responsible for the deaths as in the case of John F. Burns of the Rensselaer Institute who was struck on the temple, the same causing a fracture of the skull from which he succumbed the following day.

A pitched or batted ball striking the abdomen or heart region may produce death as in the cases of Becker and Ruhling. Young Becker was in the pitcher's box. He had succeeded in putting out two men and Towart came to bat. Becker threw over two strikes and there were two balls recorded when Becker prepared to strike him out. With great force he hurled the ball toward the plate. Towart's bat met it squarely and the lively ball was sent out in a straight line direct for Becker. He did not shirk the catch but put his hand out waist high to receive the hot liner. The ball was lower than he judged and slipped through his fingers, hitting him in the body close to the cardiac region. Only a moan was heard by his companions as the ball dropped to the ground. Becker stooped for it and then, although he staggered on his feet, threw it unerringly into the glove of the first baseman. Towart had been running toward the base but the man on first caught him out a second before he touched the bag. In watching the play the boys had not noticed the

pitcher who had fallen to the ground in an unconscious condition. Towart was the first to notice that Becker was lying on the ground but when he ran over to him he was dead.

Another peculiar accident may be mentioned in the instance of Leonard Hand, 21 years of age, who was in the pitcher's box serving to the batsman, when someone in practice before the game threw a ball directly at him. At the same time the batter hit a ball at him. In attempting to dodge them both he failed to avoid either, and both balls hit him, one behind the ear and the other on the right temple. He dropped unconscious and later died.

Still another instance may be related where Frank Kostichryz, 15 years of age, in his desire to get a hit leaned too far over the plate, reeled and fell. The ball had hit him on the right temple and in falling he broke his neck. When a few spectators rushed up and tried to resuscitate him they found the boy dead.

One man died as the result of throwing a ball from home plate to second base. After making the throw he sank to the ground unconscious. He was a retired member of the United States Navy. Heart disease was stated to be the cause of death.

During the year 1910, 33 pugilists died, 23 of these deaths were directly due to such contests, 7 were caused by disease and 3 were accidental deaths having nothing to do with the sport. In 1905, 6 deaths were due to boxing. Blood clot in the brain was the autopsy report in 2 cases; shock from blow over the heart was the cause of death in 1, while in the other 3 cases the cause of death could not be determined.

Of the 23 accidental deaths occurring during the year of 1910 only one boxer was considered a first-class man; 11 were second-raters and 5 were amateurs, the others could not be classified.

The accidental deaths due to pugilism were as follows: Fracture of the skull, 5; hemorrhage of the brain, 6; concussion of brain, 1; fracture of neck, 4; syncope, 3; acute dilatation of heart, 2; solar plexus blow, 1; internal injuries, 1.

Of the 7 pugilists who died during the year just closed from diseased conditions the cause of death was stated as follows: Heart and kidney disease, 3; pulmonary tuberculosis, 1; typhoid fever, 1; senility, 2.

The accidental deaths having nothing to do with pugilism were: Pistol shot wounds, 1; gas poisoning, 1; suicide, 1.

It will be noticed that in most of the accidents in boxing the injuries were about the head such as fracture of the skull, hemorrhage of the brain, fracture of the neck and concussion of the brain. In several of the fatal accidents it was stated that the serious injuries were produced by the head striking the floor

as in the following: "According to the verdict McCarthy met his death through a fracture of the skull sustained by striking the floor of the ring after he had been delivered a blow in the face by his adversary."

As a rule these deaths were not the result of severe punishment, but due to the poor and incomplete construction of the rings. Insufficient padding of the posts and the floor was directly responsible for the deaths. Some improvement has been made because of these accidents but there is still room for a great deal more improvement. Stretching a piece of canvas over a hard board does not make the floor any softer for the participants of boxing. It may save the head from being cut but the force of the impact on the floor has not been diminished. The trouble is that as soon as you put anything on the floor to make it softer there is less spring to the flooring and light springy footwork is absolutely necessary in boxing. One physician has invented a covering for the floor of the ring the composition of which is composed of cork for the most part. So far no boxing manager has ever given it a trial. It does, however, also make the footwork a little slow and diminishes springy movements.

To show how poorly constructed some of the rings really are the following is an illustration: "Ginger" or Edward Williams, a young heavyweight pugilist of Vistitia died on February 24, 1910, in a hospital in Coalings, Cal., from injuries suffered during a prize fight. He was knocked through the ropes in the third round and in falling his head struck a projecting board, fracturing his skull at the base of the brain.

Fatal syncope was stated to be the cause of death in three instances. These generally occurred when the victims were getting the better of their opponents as in the case of Frederick Castor, 20 years of age, who had the better of the bout so the testimony read when in the last round while trying to knock out his rival he suddenly fell unconscious.

In England and Australia six and eight ounce gloves are used in place of the four and five ounce gloves which are generally used in America. This, in a measure, would explain the small number of serious accidents in boxing in these countries as compared with the fatalities in the ring in this country. Manager McIntosh says that six ounce gloves should be in general use, especially among the heavy weights. He says that with gloves of this size anything approaching brutality is impossible. One man can not cut his opponent, but he can win on points. To mark a man is practically an impossibility. Anything that would tend to preserve a fighter's good looks would be welcomed by us here in America, where we are tired of looking at malformed cauliflower ears, broken down noses and toothless mouths.

The oldest pugilist to die in the year just closed was Jem Mace, who was considered by all Englishmen as a worthy survivor of a notable English tradition. Mace was a supreme master of a craft once esteemed by all Englishmen. He lived an honorable life of many interests, and though he died poor it was not through stupidity or dissipation. Mace lived to attain the age of seventy-nine years, and was active and well up to a short time before his death. In regard to Mace's poverty in his declining years, one must remember that no large purses, not even for champion bouts, were offered in his days.

The most tragic death during the year was the assassination of Stanley Ketchel for an alleged insult. It may be interesting in passing to note that this young pugilist had fought over one hundred battles, meeting the best men at all times, and that, although he was only twenty-two years of age, he was endeavoring to regain his health on the ranch where he was killed.

A comparison of the fatalities in the ring during the years 1905 and 1910 would show that there were four times as many deaths in the latter year. This can be explained, in a measure, for the reason that very little boxing was indulged in, comparatively speaking, during the former year, probably because the Horton law had been repealed in New York state, and one boxing bill after another had been defeated, as, for example, the Frawley bill. During 1905 glove contests were only allowed in three states in the Union while in 1910 such contests were held in many of the eastern cities every night in the week, with the exception of Sunday.

Seventeen all around athletes died during the year 1910; four of these deaths were accidental, while the remaining were due to disease.

The cause of death in the accidental cases was as follows: Fracture of skull, one; hemorrhage of the brain following training, one; infected wound, one.

Of the deaths by disease the following were stated: Heart disease, two; pneumonia, two; Bright's disease, one; pulmonary tuberculosis, one; liver disease, one; over-training, one. The particular disease which caused death could not be determined in the remaining cases.

The death of Thomas Thornton, who was a well built and active young man of twenty-one years was most unusual. He was waiting on the footway of the Pittsburg, Virginia and Charleston Railroad bridge in Pittsburg. During the wait he was amusing himself and a number of spectators with his athletic ability by leaping up a short flight of steps. On one of his leaps he miscalculated the distance and fell a distance of about eight feet, striking his head near the base of the brain. Thornton groaned once or twice, gave a few spasmodic quivers and lay flat on his face. The spectators thought he was shamming, but when they reached him he was dead.

Basketball was the direct cause of four deaths

during the year 1910. One was due to blood poisoning, one to heart dilation, one to valvular heart disease, aggravated by over-exertion and excitement, and the remaining one was stated to be from internal injuries received.

Three golf players died during the year. All the deaths were due to diseases which had nothing to do with the game directly. Willie Anderson, the most noted of any, died at the age of thirty-one of arterio-sclerosis. Mr. W. J. Weir died of paralysis in middle life. Frederick T. Oldham died at the age of thirty-two after a short illness, the nature of which was not stated.

Three deaths of oarsmen occurred during the year just passed, one from old age, one from appendicitis and in the remaining one no cause of death was stated. The ages at death were respectively, eighty-five, twenty-two and fifty-five. The elderly oarsman was Dr. F. J. Furnivall, who celebrated his eighty-fourth birthday on February 4, 1909, by rowing a racing shell on the Thames from Putney to Mortlake, the course over which the Oxford-Cambridge races are rowed.

Three deaths due to the exertion of dancing occurred during the year, one a vaudeville performer, after he had finished his act, and the two others occurred in dancing schools. Two were men, thirty-five and twenty-one years of age. The waltz was the dance indulged in in two instances, one an endurance dance of four hours' duration.

Two polo players died as the result of injuries received in the game. Both were internal injuries and the extent of each was not determined. One was supposed to be a fracture of the skull, the other player dropped dead suddenly while in a mix-up.

Two cricket players died, the result of disease the particulars of which could not be ascertained. Both were in their fifty-ninth year.

Two cyclists died, one from heart disease, which was said to have been caused by over-exertion on the wheel, while the other was an accident in a race where the heart was ruptured by the rider being thrown against an electric light pole.

Two weight lifters died, one from heart disease, while the other met his death while exhibiting his prowess. The former was fifty-eight years of age, while the latter was twenty-two years.

The other deaths were equally distributed among lawn tennis players, wrestlers, swimmers and skaters. The wrestling and swimming deaths were directly due to the same, heart failure being the cause of death in the case of the swimmer, while a dislocation of the spine, resulting in paralysis killed the wrestler.

One other death was caused by high kicking, the kick being the height of eight feet, bursting of a blood vessel, producing hemorrhage and death.

Twenty-nine aviators met their death during

the year 1910, twenty-six of these were foreigners and occurred in countries outside the United States. As a rule aviators are athletes, as in the instance of Ralph Johnstone, who was on the vaudeville stage for years before he became an aviator. Johnstone performed on the wheel, jumping up stairs one step at a time and then dropping to the stage a distance of some twenty feet. All the aeronauts of old were gymnasts, for who has not seen them perform on the trapeze just before the drop in the parachute?

When the whole subject is considered it will be found that there were a great many deaths of athletes, both by disease and accident during the year 1910, almost twice as many as in 1905, and that while the mortality rate was small in most of the games and contests it was high in a few, as for example, football, baseball and pugilism. The deaths of the aviators is only what one would expect when such a sport is in the experimental stage. Many improvements will probably be made along this line, but flying, for obvious reasons, will always be dangerous to life and limb.

In the deaths from disease it will be noted that most of the mortality was caused by diseases which affect the general circulation, such as heart disease, kidney disease, hard arteries, apoplexy and paralysis. Athletes appear to be quite susceptible to infectious diseases, and when affected with infections succumb to them as readily as others. The average age at death of athletes, taking in the accidental deaths, is markedly below that of the average person in the ordinary walks of life.

The accidental deaths in baseball appear rather large, but one must remember that this past-time is indulged in by our growing boys in every open lot and on almost every city street for over seven months in the year, and that the fatalities were purely accidental and not due to any trick or maneuver in the game. Fatal blows in the heart region as well as misdirected abdominal blows are simply accidents, more or less unavoidable where so many indulge in the sport and where great force is used to send a rather hard ball from one player to another. The game cannot, in other words, be called brutal because of the occurrence of these accidents. It will be noticed that the more proficient the players are, as for example the first-class performers, the slighter are the chances of serious injury.

The twenty-three fatalities in the prize ring also appear large, but we must remember here also that boxing was indulged in very extensively during the year 1910. If boxing laws regulating the sport in certain clubs or all clubs were in force there would be fewer deaths in the ring. Large gloves, well-padded posts and proper flooring would make accidents nearly impossible and if men were examined carefully before a contest fatal cases of syncope would not occur. As a rule accidents in the roped arena

occur in young men who do not excell. It may not be amiss to state that no serious injury or death has occurred in the prize ring among the top-notchers in twenty years' time, the last death being Andy Bowen, who fell, striking his head against a brick wall which was a part of a poorly constructed ring. The enthusiastic fight attendant desires to see the boxer who can hit, block and get away in preference to the pugilist who can slug and knows nothing of the finer points of the art. The average well-contested boxing bout is not considered brutal, but the average opinion about such contests is that they are brutal in the extreme. As others have said in the past there is no cleaner, manlier or more desirable sport.

Forty-six deaths of football players, thirty-three of which were directly due to the game, is an appalling number when one considers that the game is only played from six to eight weeks in the year. When one remembers that the high-class college men were nearly in excess of all others who succumbed as the result of the sport it is easy to see the difference between this past-time as compared with baseball and pugilism where the conditions are reversed. The game as played under the old rules in 1905 was the cause of a large number of deaths and serious injuries. The same may be said of the sport as played under the new rules in 1910. The dangerous features of the game were supposed to have been eliminated when mass play was prohibited. We have seen that the open play is still more fatal. Mass play is bad. Open play is bad and there are apparently no redeeming features attached to the sport. Unlike pugilism there seems to be no remedy or recommendation to offer to decrease the fatalities and injuries while the game is played in America. In England there is almost no danger in football as played in that country. Probably a little study and observation along this line will bring about improvement, but it is evident that in America the kicking game is not popular. When two opposing forces, each representing over a ton in weight, come together each force disputing every inch of the way, there are a series of collisions and serious injury is bound to be the result. If the present ratio continue one year from this time will show that thirty more young men will have perished as the result of football during the year 1911. Is such a sacrifice at all necessary? Cannot something be done to prevent this offering up of our young men's lives? Any young man who goes into a modern football game takes his life in his hands as figures will show.

Let us have games, athletics, athletes, baseball, pugilism, golf, polo, rowing, swimming, tennis, cricket, cycling, weight-lifting, wrestling, dancing, skating, aviation and all around performances, but, let us eliminate football as it is played in America at the present time.

PARALYSIS OF THE UPPER EXTREMITY DUE TO NERVE INJURIES.*

By NATHAN JACOBSON, M.D.,

SYRACUSE, N. Y.

IT is not the purpose of this paper to consider all forms of nerve injuries which may produce partial or complete loss of function of the upper extremity, but rather to illustrate some usual and unusual conditions encountered by presenting the histories of a few cases. The most frequent cause of partial paralysis is probably injury to the musculo-spiral nerve. In cases of fracture of the shaft of the humerus because of the intimate relationship of this nerve to the bone it is apt to be damaged to a greater or less extent. It is possible that the nerve may be completely ruptured, but more frequently some of its fibres are torn or the nerve is caught between the fractured ends of the bone or in the callus as it forms, or is stretched over the callus if any marked bending should occur at the site of fracture. The nerve can also be injured at a point lower down, namely in the lower third of the arm. Here it is not always associated with fracture. Injury to this nerve cannot always be recognized at the time of the receipt of the fracture and indeed is usually not appreciated until repair of the bone has taken place. When the splints and dressings are then removed the characteristic wrist-drop and the inability to extend the fingers or supinate the hand are observed. Loss of sensation is likewise apparent over the lower half of the outer and anterior aspects of the arm and of the middle of the back of the forearm. The degree of damage done to the nerve will obviously determine the subsequent course of each case.

I desire to call attention to some of the features as I have seen them inasmuch as they have differed somewhat from those outlined in the accepted works on fractures. Perhaps this can be made evident by the clinical pictures presented in two cases of injury to this nerve caused by fracture of the humerus.

CASE I.—Fracture of humerus with angulation; nerve not apparently damaged, but adherent to callus for distance of two inches; separation of nerve; prompt and complete recovery from paralysis.

The first case was that of a young woman, 19 years of age; a telephone operator, who was brought to me by the late Dr. J. W. Eddy, of Oswego, on April 11, 1907. She had a negative family history and had always enjoyed excellent health. On February 5, 1907, she sustained a fracture of the humerus, Dr. Eddy informed me that he had at once suspected that damage had been done to the musculo-spiral nerve because of the apparent weakness of the wrist soon after the receipt of the injury. When he brought her

to me she was unable to lift her hand or indeed move it in any way. The thumb was flexed and drawn under the fingers from which position she was unable to withdraw it. She complained of numbness over the back of the hand and forearm. Upon examination of the arm a large callus was found. An x-ray picture taken by Dr. C. E. Coon showed angulation of the bone at the point of fracture and considerable callus. These findings are apparent in the radiograph.

I operated upon her April 13, 1907, making a curved incision over the humerus at the site of the deformity. I separated the fibres of the triceps muscle and had no difficulty in exposing the nerve. It was stretched over and was adherent to the callus for a distance of about two inches. It was readily separated and did not seem to be in the least damaged. The nerve was further freed for an inch above and another below the area of adhesion and a considerable portion of the callus removed. Rubber tissue drainage was introduced. As soon as the following day the patient appreciated some improvement. She was able to move the thumb almost as freely as the other fingers. The numbness had disappeared from the back of the hand. As I removed the splints in which the extremity had been placed it seemed that there was not the same degree of wrist-drop. For a few days she complained of pain along the line of the incision. In the course of three days there was further improvement in the extensor movements of the hand. Ten days after the operation we were able to note that when the arm and forearm were placed in certain positions she could hold the hand out straight. She remained in the hospital until April 28, 1907, when she returned to her home in Oswego. I did not see her again until June 11, 1908, at which time she stated to me that the improvement had been continuous from the time she left the hospital and in the course of three months she was able to resume her work. At the date of this examination it was impossible to determine that there was the slightest impairment of motion or sensation in the extremity.

That such prompt restoration of sensation occurs where the nerve has not been visibly damaged will appear in the history of another case to be subsequently related. The prompt return of motion is also in keeping with what I have seen where no apparent injury has been done to the nerve structures. However, if thickening or other change in the nerve has occurred we have not observed the same prompt improvement. This is illustrated by a case recently admitted to my hospital service and operated upon by my associate, Dr. Coon, February 27, 1911. The nerve was found stretched over the callus and the bone united at an angle. The nerve was furthermore adherent to the bony structures and sharply constricted at one point, above which it was greatly enlarged practically forming a neuro-ma, while below the point of constriction there

* Read before the Medical Society of the State of New York, at Albany, April 18, 1911.

trauma, or (b) that the dosage of the narcotic agent was greater than consistent with safety to the patient.

From the standpoint of the anesthetic the degree and time of occurrence of any depression in the circulatory mechanism would be not only dependent upon the dosage of the anesthetic agent, but especially so upon the general pathology of the patient at the time of the anesthesia, in terms of renal function, cardiac function, vaso-motor efficiency, anemia, toxemias, etc.

If throughout one hundred narcoses for varied surgical procedure and surgical conditions the blood pressure ranged thus and so, no reliable conclusions could be deduced for use on a subsequent hundred cases whose general pathology and individual resistance must be as entirely different as their faces are different.

Given two cases of carcinoma of the breast for one or one and a half hour operation and any regular hypothetical dose of the narcotic agent for each, could the action of the blood pressure in the one case be any criterion to modification of the anesthetic dosage in the other?

Could observations on a hundred cases of carcinoma of the breast removal, include all combinations of concomitant pathological conditions, which would go to make up the surgico-narcotic behavior in one hundred other cases? In other words, could any applicable conclusion be drawn as to the action of blood pressure in the individual before one, for anesthetization, from its particular action in one hundred previous individuals of remote and varied pathological and physiological make-up?

It may well be perceived that every patient is a law unto itself as far as the effect of the anesthetic upon the circulatory mechanism is concerned, inasmuch as his particular organic make-up is different from every other and that what may be minimum dosage for one in particular might be maximum or toxic for another.

So much for the value of observations on blood pressure, as far as any influence it might have on controlling dosage of the narcotic agent is concerned.

The criteria which the anesthetist has at his command at present, if properly observed and interpreted, conveys to him knowledge which allows him to administer *minimum dosage* to each and every patient according to the reaction of that particular patient to the narcotic agent and surgical procedure, and even though early determination of depressed circulation were found by lowered blood pressure, at most, earlier institution of stimulative measures would be accomplished, for, as a matter of experience, when one has decided upon a certain surgical object neither suspension nor modification of the necessary procedure would be adopted, because the blood pressure had fallen; and again, as a matter of experience, any degree of depressed circulation which is serious enough to actually modify necessary surgical procedure can easily be

detected by the anesthetist, reported to the surgeon and combated therapeutically.

With these facts in view observations on even a long series of cases could establish no regular laws as to dosage of anesthetic agent employed, nor could it materially add to the administrative skill of the anesthetist in providing him with specially valuable advanced information leading to prevention of dire results from either anesthetic or surgical trauma.

Minor degrees of change in blood pressure would be due to such a complexity of conditions and major degrees easily detected by any intelligent observer of terminal artery and capillary.

GRAMS OF NARCOTIC AGENT TO KILO OF BODY WEIGHT.

Narcotic agents administered by means of respired air vary in the degree and rapidity of their absorption according to the condition (a) of the respiratory passages, pulmonary absorption surface and manner of breathing, and (b) the detail of the mechanical device wherewith the respiratory air is impregnated with the narcotic vapor.

Given a hypothetical weight of patient in kilos and a similar given dosage of narcotic agent in grams and the degree of effect produced would vary enormously and irregularly, dependent upon the above conditions.

Given a regular dose of narcotic agent and varied conditions of administration with varied actual absorption resultant therefrom, and the relation between that given dosage in grams to kilos of body weight can have no regular ratio.

On the one hand the child with pharynx full of adenoids, low kilo weight, requires high gram dosage to force sufficient actual absorption of narcotic agent through obstructed air passages to produce the desired narcosis, and on the other even high kilo weight with lowered vitality from severe illness requires only low gram dosage on mask with free respiratory absorption, to accomplish equally efficient analgesia and unconsciousness.

Economy of ether vapor and the partial asphyxia of any closed method of administration, diminishes the amount of ether actually used but not *a priori* the amount actually absorbed, and conversely open gauze mechanisms of administration increase the amount of ether used and wasted in the surrounding air, but by no means the amount absorbed.

So that serial observation on even one hundred cases of narcosis, with one form of mechanism for its administration, can bring out no certainly constant ratio between body weight in kilos and grams of ether or chloroform used.

Furthermore, with varying states of physiological perfection and pathological imperfection, the which bear no special relation to body weight and do play so important a part in the bodies reaction to narcotic agents, we have greater reason for disturbance in any possible regular ratio between dosage and body weight.

TWO CASES OF HEROIN HABITUATION.

By HARLOW BROOKS and H. R. MIXELL,
NEW YORK CITY.

IN a somewhat cursory examination of the current literature we have been as yet unable to find any cases of heroin habituation reported and there seems to be a general impression among the profession that this drug may be prescribed with relative immunity in this regard.

The whole question of drug habit is so important not only to the public at large but particularly to the medical profession that we therefore believe the following cases are worthy of publication. Both entered our service at the City Hospital at practically the same time. Since we have been creditably informed that the habit is by no means infrequent especially on the extreme east and west sides of the city. Druggists in these localities tell us that they believe that the prevalence of the habit is steadily growing, especially since there is now a greater difficulty in obtaining without prescription preparations containing the more active opium compounds. From the statements of our two patients there is a certain sense of stimulation and well being induced by heroin which surpasses in its delight that experienced from morphine and they assert that the habit is quite common among their associates. Apparently, judging from these two instances only, the immediate habit is broken with much less suffering and greater ease than morphinism or cocainism and the pathological and physiological effects are much less serious than in the more frequent habits.

CASE I.—M. S., female; age, 32; residence, New York state. Admitted, April 25, 1911. Discharged, May 15, 1911. Cured.

Family History.—Father died of Bright's disease. Mother living and well. Brother died of diphtheria. Grandmother on both sides had cancer. Mother has chronic rheumatism. No tuberculosis in family.

Personal History.—Born in United States of America. Occupation, housewife.

Diseases of Childhood.—Measles, scarlet fever and rheumatism several times.

Surgical.—Curretage after a miscarriage.

Menstrual.—Onset at 11 years. Normal except for amenorrhoea for three years while taking morphine.

Obstetrical.—One child, two miscarriages (three and a half, and four and a half months).

Venereal Denied.—Husband also negative in this respect.

Morphine.—Began morphine habit about ten years ago to relieve rheumatic pains, took fifty quarter grain tablets a day for four years. She then stopped for about three years, then was given glyco-heroin for a cough and soon became addicted to that drug. Took about 6 ozs. per day. Has been taking this drug steadily for about two and a half years.

Present Illness.—On admission the patient's only complaint was great nervousness and depression. No pains anywhere. Feels very weak and has a craving appetite. Bowels are fairly regular but have a tendency to be constipated. Was unable to sleep during past two

weeks. No fever, cough, or vomiting. Food stays well on stomach. She desires to be cured of her habit, which she finds expensive and troublesome.

Physical Examination.—Patient is a poorly nourished woman of about 30 years. Has a good color. Skin and mucous membranes in good condition. Not actually ill or in pain but has a nervous, anxious, apprehensive look.

Eyes.—Pupils equal, mid-contraction and react to light and accommodation. No strabismus, or nystagmus. Conjunctivæ clear.

Ears.—No discharge, topi or mastoid tenderness.

Mouth.—Tongue coated. Teeth false, pharynx normal.

Neck.—No abnormally palpable glands or pulsations.

Thorax.—Lungs normal throughout.

Heart.—Loud, prolonged systolic murmur at apex, transmitted to left axilla and to base. Pulmonary 2d sharply accentuated, aortic 2d slightly. No enlargement of heart, action good, no thrills.

Pulses equal, regular, good tension, some arterial thickening.

Abdomen, very soft and lax with many striæ. Liver felt at costal margin. Spleen not felt, no masses, ascites, tenderness or rigidity.

Extremities.—Normal contour. Skin clear. Knee jerks exaggerated on both sides. No ankle clonus, Babinski or Koernig reflex. No oedema of ankles. No spasticities, Romberg or ataxias present. Abdominal reflexes normal. No nerve tenderness. Response to heat, cold and pain normal throughout. No disturbance of cerebation. Patient answers questions normally. Is not sluggish nor excitable, mentally though somewhat melancholy.

Temperature on admission 99.2 degrees. This was the highest ever reached and it remained thereafter normal throughout. Weight, 110 pounds. Blood pressure, 140 mm.

Urine.—Cloudy, amber, acid; specific gravity, 1022; no albumen; no sugar.

Microscopical.—Heavy sediment of amorphous urates. No casts, epithelia or red or white blood cells.

Treatment.—April 25, 1911. On admission, calomel, gr. III, sod. bicarb. gr. X, codeine, gr. ss, B I D, followed in A. M. by mag. sulph 3 ss. Milk diet. April 27th, regular diet, ward tonic 3i t.i.d. A. C.

May 2, 1911.—Patient complained of feeling depressed and nervous and of severe headache which disappeared by May 3d with no medication.

May 7, 1911.—Severe griping pain in abdomen. Patient less nervous. Castor oil 3 ss given and pain cleared up.

May 8, 1911.—Codeine was discontinued with no reaction. Patient now feels well. Appetite good. No nervousness, and pains have all disappeared.

May 15, 1911.—Discharged apparently cured. Weight, 120 pounds.

CASE II.—H. H., male, single, age 26 years; admitted, April 28, 1911.

Chief Complaint.—Heroinism.

Family History.—Mother living. Father died of cancer and typhoid. No tubercular, rheumatic or neurological family traits.

Previous History.—U. S. A.; occupation, clerk. Doesn't drink or smoke.

Medical.—Typhoid eight years ago, venereal denied except for gonorrhoea nine years ago.

Surgical.—Negative.

Diseases of childhood, negative.

Present Illness.—Began taking heroin five years ago for a constant cough. He began with small doses gradually increasing until he was taking 10 to 15 grains a day. His only symptoms, except extreme nervousness were pains in back and shins, hot and cold sweats, no appetite and extreme constipation, often going a week without a movement. No cough or expectoration. Has lost 10 to 15 pounds weight in last five years and feels much weaker. No nausea, no vomiting.

Physical Examination.—Well developed and nourished male of about 26. Not actually ill but very nervous.

Skin clear, no general glandular enlargement.

Eyes, equal and react to light and accommodation. Ocular movements normal.

Tongue, slightly coated, no deviation or tremor.

Ears.—Hearing normal, no mastoid tenderness.

Nose, clear.

Upper extremities, musculature good. Reflexes active and equal.

Spine, straight, flexible, no tender points.

Heart.—Apex in fifth space, $3\frac{1}{2}$ inch L. of M. S. line. Heart not enlarged. Sounds of good, muscular quality; no murmurs; regular and good force.

Pulse, equal, regular, moderate tension; vessels soft. Lungs, normal.

Abdomen.—No rigidity, no masses or ascites.

Liver and spleen not palpable.

Lower Extremity.—Musculature good, K. J. present and slightly increased. No clonus, no Romberg, no Babinski. Sensations of heat, cold and pain, normal throughout body. No ataxias, spasticities, cerebation apparently not impaired.

Blood pressure on admission, left arm, 120, right arm, 110. Weight, 134 pounds.

Temperature.—Highest, 99.2 degrees; lowest, 98.4 degrees.

Treatment.—Atropine, gr. 1-100 q. 4 h., codeine, gr. ss. q. 4 h., whiskey, $\bar{3}$ ss. q. 4 h. Calomel, gr. III, sod. bicarb., gr. X, with mag. sulph. $\bar{3}$ i in A. M.

This treatment was continued up to May 2d, when the whiskey and atropine was discontinued. Up to that time the patient had been very restless and was unable to sleep at night. Codeine, gr. ss q. 4 h. was continued up to one day before discharge with a gradual improvement in his nervous condition.

May 4, 1911.—He complained of pains in legs from knees down along shins and in calves of legs. Had a marked non-intentional tremor, coarse tremor of hands and fingers. Complaints of sleeplessness.

May 9, 1911.—Herpes Zoster developed in right intercostal region with stinging pains both posteriorly and anteriorly. His general condition, improving, nervousness almost gone.

May 6, 1911.—Herpes Zoster almost all gone. Tremor gone. Sleeps well. General condition good. Appetite good. Bowels now not constipated. Craving for the drug has now disappeared. Weight, 140 pounds, a gain of 6 pounds.

May 23d.—Patient discharged apparently well.

depends on continued slumber of the victim. Are we guardians of the public's welfare—then awaken the public quickly. What, ho! watchman!

The secret division of fees is a menace which belongs to a coming period of degeneration, when moral relaxation is already in evidence. The menace to the state is the menace of Jugurtha bribing the Roman generals before Rome actually began to fall. An awakened public will begin to use that discriminating intelligence toward selection of physicians which we have always desired and have held to be really essential for developing efficiency. The public will then endow our institutions, close the inferior medical schools, and stop that overcrowding which allows the law of survival of the fittest to save the selfish individual rather than the ideal public servant. An awakened public will see just how dearly it is beginning to pay the penalty for its past carelessness.

I would speak particularly to the young men, to those who find the beginning of practice slow, and who fear they may not succeed unless through competing immorally. They hear various rumors to the effect that certain men are successful because they are unprofessional, and the young men do not know perhaps that success in any profession or undertaking calls out precisely the same comment with or without basis in fact. They may keep in mind the inspiring object lesson of the Mayos. A young man may surround himself with clean colleagues, whose dignity of intention is such that the circle consists of men all helpful to each other and to the public; or he may surround himself with men of negative imagination whose influence is destructive rather than constructive. Whatever the position of a young man be, it is gained through inherited tendencies and from his teachers, and he rapidly becomes one of a circle of men of his own type. *Les oiseaux d'un espece s'assemblent.*

Two or three years ago a young man whom I had known favorably as an assistant at the Vanderbilt Clinic, at that time in the department of gastro-enterology, came into my office one day and said that he was not making any headway in his practice. He said he knew it was unprofessional but understood such things were done, and would like to give me 25 per cent. of the fees for cases of gastro-intestinal trouble that I would refer to him. I asked him to be seated, to talk things over a bit. He was not very familiar with the fact that a great many of the troubles in his chosen field of practice were due to fibroid degeneration of the appendix, loose kidney, eye-strain, gall stones, and other sources of peripheral irritation. He did not note if patients in his field of practice ever carried stigmata of defective development, such as gun stock scapulæ, high-

SECRET DIVISION OF FEES.*

By R. T. MORRIS, M.D.,

NEW YORK CITY.

WE should all be thankful that Dr. Brettauer has brought forward this subject in such a decisive way at the present time. Some very excellent men deprecate the discussion of this topic of secret division of fees because of their fear that the whole profession will be brought under suspicion. They are wrong. Bright sunlight and fresh breezes are always purifying agents.

Should we be careful about awakening a slumbering public? If the public is our prey and we are vampires—yes! for our sustenance

* Discussion on an address by Joseph Brettauer, M.D., given before the Educational Alliance, April 23, 1911.

arched palates, ear-lobes running into the neck, and other common signs, and he did not give these signs any relative value as bearing upon the factors of neurosis in problems in his field, in brief, he did not understand his business. That was the reason for his failure; that was the reason why he was willing to commit professional prostitution, for precisely the same reason that women become prostitutes—through poverty and lack of an economic degree of proper information, leaving out all æsthetic questions. What he wanted to do, I suppose, was to inflict upon my patients the weary conventional round of test meals and diets which exhaust everybody connected with the case. He wanted to give me 25 per cent. of what the poor devils have to pay in addition to their physical misery. Were I open to insult from anybody, this would be about as close a call as I have ever had in any field of activity. Had this young man really comprehended the nature of his chosen field of practice he would have had little difficulty in soon getting his hands full of—professional work. I was about to say “business”; thank Heaven the word “business” did not slip my lips.

We cannot allow any deviation in our methods from those adopted by and acceptable to the representative men in the profession.

Some twenty years ago in the western part of the state I had occasion to do some work with a physician who liked to get together all of the bills connected with a case, and have them presented as a lump sum. They included local hospital expenses, his own visits, my work, the charge of the anesthetist, and everything connected with the case. It was his way of doing things, with the full compliance of his patient. It did not occur to me at that time that such a method gave opportunity for abuse, but shortly afterward another physician in the town asked me if I would care for one of his cases in the same way, and I heard subsequently that he had sent a separate bill in addition for his own services. Another case which he referred to me was referred with the expectation that I would send him a part of the proceeds. Noting the trend of such arrangement, I have refused ever since to take part in any such plan, and there have not been more than three or four occasions in the past twenty years when it was desirable for any reason to make one charge cover all expenditures.

One case belonging partly to this group occurred recently. A young man sent a case for operation, and proposed that I give him a part of the fee as he was giving up all interest in the case. I explained to him that it was a commercial conception of the situation, that he was not planning to get proper credit for his own interest in the case, and for his own subsequent management of it; that it would be very much more to his credit if we were to

do the work in this case together, the case being one of a sort in which this was possible. His bill would be included in mine, but my bill would be itemized with a statement of the proportion for his services, and he would then not surrender his interest in the case, but would maintain a position which would be appreciated by the patient, who would have higher regard for him than otherwise. He finally consented to the plan, and it worked out as I had predicted, but was close to the danger line.

Some years ago I knew of an eminent surgeon giving a disproportionate “assistance fee” to a family physician. He was a generous man, and this was a thoughtless act on his part I am sure, as he was not the sort of man to leave a bad taste in the mouth of anybody.

As a matter of fact, in my own practice there have been so few proposals for rebating in the course of twenty-five years that I would hardly believe the custom to exist in New York excepting for reports to which one is bound to give some sort of credence.

Some years ago a doctor came on from Indiana with a patient for operation, stated that I could charge \$1,000 for the work, and he would like \$250 for his time and trouble. I told him there would be no objection at all so long as the patient understood it in that way; and he said that he could not allow the patient to understand it in that way because “the patient was a friend of his.” Further comment on the subject of friends is unnecessary. It was impossible to make any arrangement by which I could do the work.

Every surgeon of established position has cases coming to him from all over the country, the patients often accompanied by their physicians, diagnosis all made, patients ready to pay liberally for the work, and yet it is found that many of the cases are not cases for operation at all, or they are cases in which operation would solve only a part of the problem. The patients often must be sent to other authorities, and the responsible surgeon foregoes his own fee entirely in order that the patient may be placed in proper hands. Surgeons who try to be responsible may not operate upon more than half of the patients sent to them, and who are ready for operation if the surgeon so decides. What are the chances of such patients at the hands of rebaters?

One experience in another part of the question came not long ago. A physician whom I had known in former years, interested in obstetrics, moved to my part of the city, and I sent him the first obstetric case in which my advice was asked in reference to an attendant. After the patient was delivered, what was my surprise one day to receive a check from the doctor for \$50. The check was promptly returned with the statement that skilled ser-

vices were worth all or more than was commonly paid, without leaving any margin for other people. He has had no more obstetric cases referred by me, and whenever I pass him in the street it is with feelings of discomfort at my disappointment in him.

From time to time I heard that a certain member of the New York Surgical Society had been guilty of rebating, but I did not seriously consider any such report, which might be made carelessly. It was my impression that no man guilty of rebating could gain admission to the Surgical Society in the first place, and in the second place the influence and spirit of that association would be quite opposed to the development of any such trait. Two weeks ago, however, while at Ossining, a physician of that town informed me that he had sent a case for operation to this surgeon, who had charged \$1,000 for the work and had sent him a check for \$300. The Ossining doctor promptly returned the check, although he really needed any nice little sum of this sort. Think of the temptation to honorable men in every part of the country offered by such an act. The surgeon in question was a man who had done brilliant and original work in his profession, but the poor fellow, from overwork, no doubt, was said to have acquired the morphine habit and it was this, presumably, which had made him lose caste, and to become careless in the moral side of his professional work along the well known lines of morphine influence.

When the optometry bills came up before various legislatures many members of the profession wondered at the success of opticians opposed to oculists, but the facts leaked out. Any oculist who has accepted a commission for spectacles is emasculated, and so many have suffered this accident that in our time of need at the state capitols there were not enough oculists with horns to protect the public, themselves, or the medical profession. Opticians were able to quietly show legislators that they were simply in "competitive trade" with oculists, and the legislators looked at the matter in that way. I know a man who has a pocketful of checks paid by opticians to oculists for commissions and endorsed by oculists or by secretaries of clinics. When the time came for attack upon an enemy, instead of roars of courage, and rending the enemy with vigorous horns, they could only butt the enemy with soft heads, uttering feeble squeaks.

Our calling is so high that very little deviation from the perpendicular destroys the center of gravity and creates a tangential thrust at the base.

We have known for some time that rebating occurs in some parts of Europe, and not long ago while at a hotel in a foreign city I informed the physician with whom I happened to be in conversation that it was my intention

to proceed to the town of a certain surgeon in order to see his work. In a perfectly matter of fact way he replied: "Oh, yes, he does quite remarkable work, and only last week sent to me payment for a case which I had referred to him." On further conversation my plans to visit this surgeon were changed, as I could have no heart in his science after that. On further conversation the physician told me it was quite customary for him to receive payment also for cases which he referred to different sanitariums. I must confess to having had the feeling of the Pharisee, and was thankful to know that in our good country hotel physicians are still honorable men, and our sanitariums, at least those with which I am familiar, are interested in the welfare of the patient only, paying no commissions to physicians who refer patients.

The moment that secret division of fees enters, the whole principle of our relations toward the people changes as quickly as the vane on the church spire goes from west to east on the changing winds of a falling barometer. People are no longer objects of our scientific and heart-felt solicitude, but they become our prey, and the trusted family doctor becomes a tumble-bug wallowing in the carrion. He is no longer the man who in the interest of his patient makes us surgeons charge too small fees, but he uses the confidence of the people for the purpose of cutting out for himself as large a piece as possible.

In the circles of nobility in the medical profession I have always had a good deal of complaint to make against the family physician.

When an operation worth \$25,000 was done he would make me charge \$2,500 instead. If the operation was one in which \$2,500 would have been a perfectly fair charge he would persuade me to charge \$500.

It is easy to see how one might press a button and ring up a different sort of character in the doctor who guards the interest of his patient as a good lawyer protects his client in every point.

We must always keep in mind the etymology of the title "doctor." Finding the people ignorant, shall we teach them?—or finding the people ignorant shall we prey upon them?

The secret division of fees belongs to a beginning era of decadence, when the chimes are ringing for the closing exercises of families, and when the most beautiful apartments in the cities are built for the double roses of culture which are no longer able to propagate their kind; but thank God the ideals of our profession are ideals of intellect, ideals of character, ideals of utility and of goodness. We shall always have teachers at the head of the profession who represent such ideals, and there will always be a sufficient number of these to

inspire our young men. There will always be William McClures in abundance as well.

Perhaps this is a moment of great opportunity for our New York Academy of Medicine. We may be a little envious of Erie County for having made the first definite move in the way of setting standards and eliminating defects; but if at this opportune moment a representative body like the New York Academy of Medicine would arrange a plan for allowing men to register their opinions on the subject of secret division of fees, the ones who failed to register properly would make an easy classification, and in this way we could make the Empire City of the Empire State openly committed to sentiments which will influence the entire nation."

MUTUAL HELPFULNESS IN THE CONSERVATION OF PUBLIC HEALTH.*

By WILLIAM A. HOWE, M.D.,

PHELPS, N. Y.

MINDFUL as I am of your time limitations, especially this afternoon, I shall not detain you with introductory words, but pass promptly to my subject, deal with it briefly and invite for it your liberal consideration.

Though as a department we are enjoying a most pleasant relationship with the medical profession of the state, which we deeply appreciate, we are nevertheless conscious of the fact, that such relationship should be more practical, more mutually co-operative or reciprocal, more helpful one to the other and hence more conducive to our ideals of giving to the people of the state the most efficient service possible in matters pertaining to the conservation of their health. As a department we want to get nearer to you as practitioners and have you get nearer to us. We want you to feel that the department belongs equally as much to you, and is equally as much at your service, as to the health officer, who is the legal medium of distribution of supplies furnished to you and to the people, by the department. We are anxious to have you familiarize yourselves with the methods and resources of our department, particularly such of them as should be at your command. You should fully understand what we can do for you and your people, and how to set about to have it done. You should learn the conditions under which we furnish diphtheria and tetanus antitoxin, and culture tubes for diphtheria, Widal or ophthalmia neonatorum outfits, circulars of instructions on all communicable diseases, illustrated lectures or lecturers on popular health topics, medical officers or expert diagnosticians, sanitary engineers, etc., etc.

It is with these thoughts in mind, and with

this desire, that I am prompted to appear before you to-day to briefly outline a few of the things which Commissioner Porter is desirous of doing for the practitioners of this state, and in turn to urge your cordial reciprocation by doing certain things for the department over which it is his honor to preside. As might well be expected there are certain financial and physical limitations to our resources. So far, however, as funds at our disposal and our working forces will permit, the department will welcome every opportunity to serve you, and through you the people of the state, in all matters pertaining to sanitation. Let me tell you of a few of the ways in which the department can be of assistance to you and to your families.

1. *Laboratory Diagnoses.*—The State Hygienic Laboratory through the medium of the local health officer is always at your service for diagnostic purposes and should be so utilized by you far more frequently than has been your custom in the past. There is probably no branch of the department in which we can render you such practical assistance as at the Laboratory. We can often settle for you a questionable diagnosis in diphtheria, tuberculosis, typhoid fever or cerebrospinal meningitis. We can tell you whether your suspect be a typhoid carrier or your municipal water supply is in a polluted condition. We can give to your local health officer such practical instruction in modern sanitation as will enable him to serve his people in a far more intelligent and efficient manner. In short, at the laboratory we can do much for you and for your people, and we court the privilege of doing it.

2. *Distribution of Diphtheria Antitoxin.*—Inasmuch as the fundamental principle underlying the policy of the department, is the conservation of public health, its commissioner is anxious that diphtheria antitoxin shall be liberally distributed and generously administered both as a therapeutic and prophylactic measure. While those who can well afford it are expected to purchase the remedy elsewhere, no case of diphtheria should be permitted to go unprotected for want of this remedy *par excellence*. The Commissioner has repeatedly ruled that a man earning only moderate wages, with a family to maintain should not be expected to pay \$25 or even more for sufficient antitoxin with which to save the life of his child, and protect the other members of his household. Our 1,400 or more health officers throughout the state have been thus instructed and on request should gladly furnish this remedy to you for such purposes. Let me urge you to use the state antitoxin. Use it early, use it freely, and use it rightly and diphtheria will soon be stripped of much of its remaining mortality.

3. *Tetanus Antitoxin.*—That which has been said regarding the distribution and administration of diphtheria antitoxin is equally as true of tetanus antitoxin. While the greatest field of usefulness for this serum is as a prophylactic, several instances have been reported to us during

* Read before the Medical Society of the State of New York, at Albany, April 19, 1911.

the past year in which a favorable outcome followed its administration even after the invasion of tetanic symptoms. We are also anxious that you should employ this remedy in every case in which tetanus infection might have arisen. In every doubtful case give the patient its benefit. The remedy should always be at your service through the health officer, and all we ask is to have it so liberally administered as will spare the lives of those who are each year succumbing to its needless fatality.

4. *Ophthalmia Neonatorum*.—For nearly two years the department has been supplying to the medical profession and midwives throughout the state, ophthalmia neonatorum outfits to be used in all cases of childbirth. These outfits consist of a small vial of a 1 per cent. solution of nitrate of silver, together with a sterilized dropper. This effort to suppress ophthalmia neonatorum throughout the state, with its oft-resulting blindness, has been so generously supported by the profession that to-day it would appear that in practically all cases of childbirth either the silver solution or some other prophylactic is being employed. These supplies, like all others furnished by the department, should be obtainable by you at any and all times from the local health officer.

5. *Monthly Bulletin*.—Most of you have no doubt seen and read the *Bulletin* which is issued each month by the State Department of Health. So far as funds for that purpose would permit, Commissioner Porter has endeavored to send this official organ of the department to such physicians of the state as have expressed a desire to receive it. Were he able to do so, I am sure the Commissioner would be more than pleased to place regularly, a copy of this publication in the hands of every physician of the state, with a view of keeping them fully informed as to our activities, and further increasing their interest in our efforts along the lines of preventive medicine.

6. *Medical Officers, Expert Diagnosticians, and Sanitary Engineers*.—The department is in constant readiness to despatch to any community of the state one of its medical officers, or expert diagnosticians, or sanitary engineers, to study the origin of any localized outbreak of any communicable disease, or to render expert service in determining the true character of a disease under disputed diagnosis. These trained sanitarians can also render invaluable assistance to your municipality in other matters pertaining to public health. When in trouble or in doubt over local health matters, let me urge you to consult your health officer. If he cannot relieve the situation alone, let him ask the department to come to his aid and your assistance with one of its medical officers, its expert diagnostician, or its sanitary engineer. Do not forget that whatever resources are at our command are always at your service. You should know this and should feel at liberty to avail yourselves of them, not only for your

personal advancement, but for the welfare of those whom you serve.

Now that I have told you a few conditions under which the State Department of Health can and would like to assist you, my story would be incomplete did it not mention certain matters in which we urge you to reciprocate.

First.—Improve every opportunity to thoroughly familiarize yourselves with such of the resources of the department as might be useful to you and to your people, and having done so utilize these privileges. Many valuable and precious lives are no doubt sacrificed in this state every year because the practitioner is either unfamiliar with his accessibility to these privileges, or because he refuses to avail himself of them. This should not be so, nor would it, except to a minor extent, were the medical profession of the state and the State Department of Health co-operating more closely and more extensively in a spirit of mutual helpfulness.

Second.—*Faithfully support your local health authorities, particularly the health officer*. It is easily within your power to make the local health officer one of the best, by assisting him, or one of the most unsuccessful in the state, by embarrassing his administration. While he is the chosen medium by which the department reaches the people, it should be clearly understood, by every physician in the state, that the services of the department are equally as much at his service and at the service of his clientage, as at the service of the health officer. You should regard the health officer as much at your service and at the service of your people, as you do any other public officer. At the same time you should consider it equally as much your moral duty, as well as a privilege, to do such as you can to contribute to a successful administration of the duties incident to his office. His relation to you in all communicable diseases should be that of the sanitary consultant or assistant, and your relation to him should be one of mutual helpfulness in all matters pertaining to the management of transmissible diseases. There is no reason why your interests should be divergent, neither is there any reason why you should not assist each other and far better conserve the health of the people, entrusting themselves to your care. As in the past, the State Department of Health will continue to exert its influence to cultivate and maintain such mutual relations between its health officers, and the physicians of the state, as will prove conducive to the most efficient service possible in all matters pertaining to public health.

Fourth.—*Do such as you can to induce your best citizens and your leading physicians, to become identified with the local Board of Health, and by their activities to contribute to its successful administration*.

Fifth.—*Exert your influence, and that of your friends, to improve the general sanitary condition*

of the community in which you live. Promptly notify the health officer of the prevalence of any unsanitary condition which may come under your observation, and whenever possible advise and assist him, as to the most effective means to employ to remedy the same.

Sixth.—By all means report promptly every birth, death and communicable disease which may occur in your practice. This failure on the part of the practicing physician, to report such cases, occasions one of the most serious embarrassments with which we meet at the department. This, on your part, I am satisfied is more a matter of habit than intention, in which case if you will only cultivate the *better* habit of making prompt and complete reports, you will materially lessen our troubles, and greatly contribute to the efficiency of the work of the department.

Seventh.—When a communicable disease has occurred in your practice, and you have reported the same to the health officer, unite with him in such sanitary management of the case as will insure to the public the greatest possible protection from further contagion or infection.

Eighth.—Communicate with the department regarding any obscure case which may come under your observation. You may be sure we will be interested in it, and if we cannot assist you ourselves, we may be able to refer you to some one who can. Feel privileged to offer suggestions to the department, not only relative to local health matters, but such as may pertain to general sanitation.

Ninth.—When in Albany call at the department, or at the State Hygienic Laboratory to get acquainted with us and the products of our laboratory. You will always find a welcome at either place, and so far as it may be possible we will serve you for the one great purpose for which the department is maintained, the conservation of the health of the people of the state. Do not be reluctant to ask questions, as they are the greatest possible means of imparting and receiving knowledge. Do not think that you are making us trouble, but that it is our desire to save you trouble.

In closing, my friends, let me appeal to you, the physicians of this state, to join hands with the State Department of Health in an evangelization of the health of our people. Let me urge you to unite your potential influences to the endeavors of the department, to accomplish that which Osler so graphically portrays in his "Man's Redemption of Man." Let us in our united strength raise a standard of sanitary living so lofty, yet so simple, that even the humble subject in following its precepts may find health and happiness. Let us in our combined energies insure to the people of this state one of the most efficient health services in the world, but let us appreciate that a realization of such idealistic conditions, can be made possible only by an enthusiastic co-operation between the practitioners

and the health authorities of the state. Let us remember that the greatest and most fruitful reciprocity of mankind, is that which has for its sublime purpose the conservation of human life. We, as a department, pledge to you and to the people our untiring devotion to obtain this purpose. But to accomplish it, we must have the solid medical profession with us. Will you come?

GANGRENOUS APPENDICITIS SECONDARY TO PUERPERAL SEPTICAEMIA.

By CHARLES C. ZACHARIE, M.D.,

WHITE PLAINS, N. Y.

IT is not the purport of this paper to reiterate on the well-known subject of appendicitis and its treatment, but merely to state the facts of this one particular case which extended over a period of nearly two months with complete recovery aided by serum treatment.

Mrs. B., a young woman of 19, gave birth to a child on April 21, 1911, this being her second child born in two years and labor very difficult in both instances, on account of a justo minor pelvis. Both children were males and are in perfect health. The case which I am about to describe was a breech presentation with forceps delivery on after coming head, both arms were extended above head, child was delivered in the usual way, weighing nine pounds, with slight laceration in left vaginal wall which was immediately repaired. She did fairly well until the fourth day of her delivery, as temperature chart will show, when temperature started to rise, followed with chills and rapid pulse, foul odor from vagina. Stitches were removed from laceration and vaginal douche of lysol given. Temperature subsided to normal but shot up on following day, rising and falling, as chart will show, uninfluenced by treatment of any kind. There were no signs of any general or localized peritonitis and no pain or tenderness anywhere. Blood culture negative and blood count normal. Again, after many days of high temperature with morning falls, on the morning of the 6th of May the temperature reached normal, just fifteen days from birth of child. Patient seemed fairly well until May 12th when she complained of pain in right side region of right ovary, no distension or rigidity. Vaginal examination showed some slight tenderness in region of right tube and ovary and palpation on abdomen over that region showed pain and tenderness on pressure, unable to feel any tumor. On the evening of the 13th of June patient had violent chills and temperature reached 105, a small mass developed in right side region of uterus. Ice bag was applied and on the morning of the 14th, temperature being 105 and pain and tenderness quite severe, I had patient removed to the White

"Hay Fever: Adrenalin

I never think of the first without thinking of the second. There is nothing strange about that, though. The Adrenalin preparations 'fill the bill'; and you are not over-modest about telling us so."

A medical practitioner said this to us the other day. There is a sting in the last sentence. We are not greatly offended, however. In fact, we admit the justice of the impeachment. We do sound the praises of the Adrenalin products occasionally. These preparations, in our opinion, afford the most satisfactory palliatives in hay fever—and we want the medical profession to know it. That is why we are publishing this announcement. Our medical friend unconsciously provides us with a better advertisement than we could write if we tried all summer—and we cheerfully give him the top of the page.

SOLUTION ADRENALIN CHLORIDE

Adrenalin Chloride, 1 part; physiological salt solution (with 0.5% Chlorotone), 1000 parts.

Dilute with four to five times its volume of physiological salt solution and spray into the nares and pharynx.

Ounce glass-stoppered bottles.

ADRENALIN INHALANT

Adrenalin Chloride, 1 part; an aromatized neutral oil base (with 3% Chlorotone), 1000 parts.

Dilute with three to four times its volume of olive oil and administer in the manner described above.

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[NOTE.—We also supply Adrenalin Ointment and Adrenalin and Chlorotone Ointment, both successfully used in the treatment of hay fever.]

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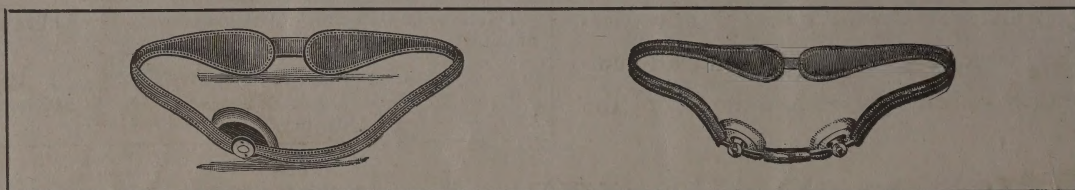
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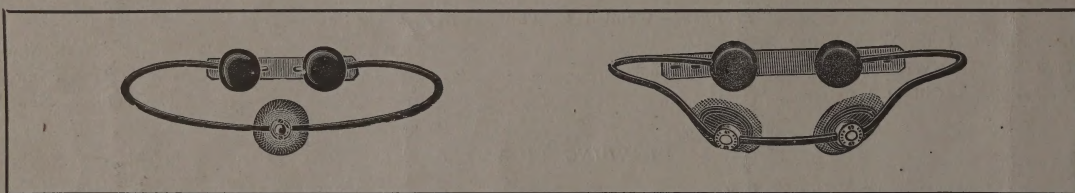
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